Viral Hepatitis Case Report

Perinatal Hepatitis B Virus Infection

Michigan Department of Community Health

Communicable Disease Division

Investigation Information

Investigation ID	Onset Date *mm/dd/yyyy*	Diagnosis Date *mm/dd/yyyy*	Referral Date *mm/dd/yyyy*	Case Entry Date *mm/dd/yyyy*	Case Completion Date *mm/dd/yyyy*

Investigation Status	Case Status
	○ Confirmed ○ Not a Case ○ Probable ○ Suspect ○ Unknown

Patient Status	Patient Status Date *mm/dd/yyyy*	Part of an outbreak?	Outbreak Name	Case Updated Date *mm/dd/yyyy*

Patient Information

Patient ID	First	Last	Middle

Street Address

City	County	State	Zip

Home Phone *###-###-####*	Ext.	Other Phone *###-###-####*	Ext.

Parent/Guardian (required if under 18)

First	Last	Middle

Demographics

Sex	Date of Birth *mm/dd/yyyy*	Age	Age Units
○ Male ○ Female ○ Unknown			○ Days ○ Months ○ Years

Race
(Check all that apply)
☐ Caucasian ☐ African American ☐ American Indian/Alaska Native ☐ Hawaiian/Pacific Islander ☐ Asian ☐ Unknown
☐ Other (Specify)

Hispanic Ethnicity	Arab Ethnicity
○ Hispanic/Latino ○ Non-Hispanic/Latino ○ Unknown	○ Arab ○ Non-Arab ○ Unknown

Worksites/School	Occupations/Grade

Referral Information

Person Providing Referral

First	Last	Phone *###-###-####*	Ext.	Email

Case ID *First Name* *Last Name* *Viral Hepatitis Case Report* *Page 2*

Referral Information cont.

Primary Physician

First	Last	Phone ###-###-####	Ext.	Email

Street Address

City	County	State	Zip

Case ID *First Name* *Last Name* *Viral Hepatitis Case Report* *Page 3*

Hospital Information

Patient Hospitalized	Hospital	Hospital City	Hospital Record No.
○ Yes ○ No ○ Unknown			

Admission Date *mm/dd/yyyy*	Discharge Date *mm/dd/yyyy*	Days Hospitalized

Clinical Information and Patient History

Place of Birth:	Did the patient die from hepatitis?	If yes, specify the date of death: *mm/dd/yyyy*
○ USA ○ Other	○ Yes ○ No ○ Unknown	

Reason for Testing:
(Check all that apply)

- ☐ Symptoms of acute hepatitis
- ☐ Screening of asymptomatic patient with reported risk factors
- ☐ Screening of asymptomatic patient with no risk factors (e.g., patient requested)
- ☐ Prenatal screening
- ☐ Other
- ☐ Evaluation of elevated liver enzymes
- ☐ Blood / Organ donor screening
- ☐ Follow-up testing for previous marker of viral hepatitis
- ☐ Unknown

Is the patient symptomatic?	Is or was the patient jaundiced?	Is or was the patient pregnant?	If yes, specify the due or delivery date: *mm/dd/yyyy*
○ Yes ○ No ○ Unknown	○ Yes ○ No ○ Unknown	○ Yes ○ No ○ Unknown	

Diagnosis:
(Check all that apply)

- ☐ Acute hepatitis A
- ☐ Acute hepatitis B
- ☐ Acute hepatitis C
- ☐ Acute hepatitis E
- ☐ Chronic HBV infection
- ☐ HCV infection (chronic or resolved)
- ☐ Acute non-ABCD hepatitis
- ☐ Perinatal HBV infection
- ☐ Hepatitis Delta (co- or super-infection)

Diagnostic Tests

Test Name	Result
	(P=Positive N=Negative UNK=Unknown)
Total antibody, hepatitis A virus [total anti-HAV]	
IgM antibody to hepatitis A virus [IgM anti-HAV]	
Hepatitis B surface antigen [HBsAg]	
Total antibody, hepatitis B core antigen [Total anti-HBc]	
IgM antibody, hepatitis B core antigen [IgM anti-HBc]	
Antibody to hepatitis D virus [anti-HDV]	
Antibody to hepatitis E virus [anti-HEV]	
Antibody to hepatitis C virus [anti-HCV]	
Supplemental anti-HCV assay [e.g., RIBA]	
HCV RNA [e.g., PCR]	

anti-HCV signal to cut-off ratio

Liver Enzyme Levels at Time of Diagnosis

Test Name	Result	Upper Limit Normal	Date of Result
			(mm/dd/yyyy)
ALT (SGPT)			
AST (SGOT)			

Case ID *First Name* *Last Name* *Viral Hepatitis Case Report* *Page 4*

Epidemiologic Information

Race of Mother:
◯ Caucasian ◯ African American ◯ American Indian/Alaska Native ◯ Hawaiian/Pacific Islander ◯ Asian ◯ Unknown ◯ Other (Specify)

Ethnicity of Mother:
◯ Hispanic/Latino ◯ Non-Hispanic/Latino ◯ Unknown

Was Mother born outside of the United States? ◯ Yes ◯ No ◯ Unknown	If yes, what Country?

Was the Mother confirmed HBsAg positive prior to or at time of delivery? ◯ Yes ◯ No ◯ Unknown	If no, was the Mother confirmed HBsAg positive after delivery? ◯ Yes ◯ No ◯ Unknown	Date of HBsAg positive test result: *mm/dd/yyyy*

How many doses of hepatitis B vaccine did the child receive? ◯ Zero ◯ 1 ◯ 2 ◯ 3 or more	Dose 1 Date *mm/dd/yyyy*	Dose 2 Date *mm/dd/yyyy*	Dose 3 Date *mm/dd/yyyy*

Did the child receive hepatitis B immune globulin (HBIG)? ◯ Yes ◯ No ◯ Unknown	If yes, on what date did the child receive HBIG? *mm/dd/yyyy*

Case ID *First Name* *Last Name* *Viral Hepatitis Case Report* *Page 5*

Lab Results

Report Date	Test Name	Test Result	Specimen	Collection Date
(mm/dd/yyyy)				*(mm/dd/yyyy)*

Case ID *First Name* *Last Name* *Viral Hepatitis Case Report* *Page 6*

Other Information

Local 1	Local 2

Name of Person interviewed	Relationship to patient	Date of interview *mm/dd/yyyy*

Submitted by:	Date *mm/dd/yyyy*	Health Department	Phone Number *###-###-####*	Ext.

Other Information cont.

Comments or Additional Information

Case ID *First Name* *Last Name* *Viral Hepatitis Case Report* *Page 8*

Case Notes

Notes